July 1, 2005 – June 30, 2006

Benefit	CareFirst BlueCross BlueShield Preferred Provider Program	
	In-Network	**Out-Of-Network**
	$250 Individual/$500 Family	$500 Individual/$1,000 Family
Out-of-Pocket Maximum	None	$2,000 Individual/$4,000 Family
PHYSICIAN SERVICES		
Surgeon	100% AB after deductible	Covered at 80% of AB after deductible
In-Hospital	100% AB after deductible	80% AB after deductible
HOSPITAL		
Hospital Room/Semi Private*	100% AB after deductible/365 days	80% of AB after deductible/365 days
Outpatient surgery	100% AB after deductible	80% of AB after deductible
Emergency Care (within 72 hours) • Accidental Injury • Medical Emergency	100% AB, no deductible 100% AB after a $35 facility/$35 physician Copay (waived if admitted)	100% AB, no deductible 100% AB after a $35 facility/$35 physician Copay, 100% AB if admitted
MEDICAL SERVICES		
Diagnostic X-rays	100% AB, no deductible	80% AB, in office after deductible 100% AB hospital no deductible
Radiation & Chemotherapy	100% AB after $35 facility Copay and $20 physician Copay	80% AB after deductible
Laboratory Tests	100% AB, no deductible	80% AB after deductible
Allergy Testing	100% AB after $20 Copay	80% AB after deductible
Allergy Treatment/Injections	100% AB after $20 Copay	80% AB after deductible
Physical Therapy	$20 Copay office/$35 outpatient facility Copay per visit; $20 professional Copay. 100 visit limit, authorization required after 10th visit	80% AB after deductible 100 visit limit per benefit period; authorization required after 10th visit
PREVENTIVE CARE		
Well Baby & Child Care	100% AB after $20 Copay (no deductible)	80% AB (waive deductible)
Immunization	100% AB (no deductible)	80% AB (waive deductible)
Annual Physical Exam	One per calendar year age 18+; $20 Copay; 100% AB up to $200 maximum includes routine diagnostic tests (no deductible)	One per calendar year age 18+; 80% AB, $200 maximum includes diagnostic tests (after deductible)
Annual Gynecological Exam	One per calendar year $20 Copay; 100% AB (no deductible)	One per calendar year 80% AB after deductible
Eye Exams	No benefit for routine exam	No benefit for routine exam
Eye Glasses	No benefit	No benefit
OFFICE		
Medical Visits for Illnesses	100% AB after $20 Copay per visit; (no deductible)	80% AB after deductible

	In-Network	Out-Of-Network
SPECIAL SERVICES		
Home Health Care Visits	90 days of unlimited visits covered at 100% AB; no deductible (approved plan treatment required)	90 days of unlimited visits covered at 100% AB; no deductible (approved plan treatment required)
Maternity Care	100% AB after deductible	80% AB after deductible
Infertility services Artificial Insemination & In Vitro Fertilization	Not covered	Not covered
Ambulance (when medically necessary)	100% AB no deductible (ground only)	100% AB no deductible (ground only)
MENTAL HEALTH/SUBSTANCE ABUSE COMBINED		
Inpatient Care*	Inpatient Hospital: 100% AB (no deductible) Halfway House: 100% AB (no deductible)	Inpatient Hospital: 80% AB (no deductible) Halfway House: 80% AB (no deductible)
Outpatient Care (services must be preauthorized)	Visits 1-5, 80% AB no deductible Visits 6-30, 65% AB no deductible Visits 31+, 50% AB no deductible	Visits 1-5, 80% AB after deductible Visits 6-30, 65% AB after deductible Visits 31+, 50% AB after deductible
PRESCRIPTION DRUG PROGRAM		
	$10 Copay – generic drugs $20 Copay – brand-name preferred drugs $35 Copay – non-preferred drugs Maintenance drugs: Retail – 3 Copays Mail Order – 2 Copays	$10 Copay – generic drugs $20 Copay – brand-name preferred drugs $35 Copay – non-preferred drugs Maintenance drugs: Retail – 3 Copays Mail Order – 2 Copays

This chart contains highlights only and is subject to change.
AB-Allowed Benefit.
**Inpatient stays require precertification.*